DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 3101 PLUMAS RENO, NV 89509 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CROS	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 3101 PLUMAS RENO, NV 89509 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE O6/17/2008 STREET ADDRESS, CITY, STATE, ZIP CODE 3101 PLUMAS RENO, NV 89509 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPL COMPL DAY COMPL DAY DAY DAY DAY OF THE PROVIDER'S PLAN OF CORRECTION (X6) COMPL DAY COMPL DAY DAY DAY DAY DAY DAY DAY DAY				A. BUILDING			С	
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F 000 INITIAL COMMENTS F 000	F 000	INITIAL COMMENTS		F 000				
Surveyor: 19948 This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on June 16, 2008. Complaint #NV00018385 alleged that the facility over-sedated residents. The complaint was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any parfy under applicable federal, state, or local laws.		This Statement of De a result of a complain your facility on June Complaint #NV00018 over-sedated resident unsubstantiated. The findings and comby the Health Division prohibiting any criminactions or other claim available to any party	at investigation conducted at 16, 2008. Base alleged that the facility its. The complaint was clusions of any investigation in shall not be construed as ital or civil investigation, its for relief that may be					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE